STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING _____ B. WING _____	R-C 07/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES HEALTH CARE CENTER	**3301 N CALUMET AVE VALPARAISO, IN 46383**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00146835, IN00147018, and IN00147189 completed on April 8, 2014. This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR to the Investigation of Complaints IN00142493, IN00142570, and IN00142795 completed on March 13, 2014. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00145475 and IN00145829 completed on March 13, 2014. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00147839, IN00147865, and IN00148335 completed on April 29, 2014. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00149735 completed on May 27, 2014. This visit was in conjunction with the Investigation of Complaints IN00150240 and IN00151978. Complaint IN00146835- Corrected Complaint IN00147018- Corrected Complaint IN00147189- Corrected Survey dates: June 30, 2014 and July 1 & 2, 2014.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING _____ B. WING _____	R-C 07/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES HEALTH CARE CENTER	**3301 N CALUMET AVE VALPARAISO, IN 46383**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1	{F 000}		

Facility number: 000176
Provider number: 155277
AIM number: 100288940

Survey team:
Janet Adams, RN-TC
Regina Sanders, RN

Census bed type:
SNF: 6
SNF/NF: 75
NCC: 5
Total: 86

Census payor type:
Medicare: 6
Medicaid: 53
Other: 27
Total: 86

Sample: 20

Whispering Pines Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the Investigation of Complaints IN00146835, IN00147018, and IN00147189.

Quality review completed on July 3, 2014, by Janelyn Kulik, RN.